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	17E294	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents. Based on record review and staff interview, the facility failed to incorporate the 6/17/11 Centers for Medicare and Medicaid Services (CMS) letter entitled :'Reporting reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act" into the existing facility policy. Findings included: - The undated facility policy titled "Abuse and Neglect" lacked information regarding reporting of suspicion of crimes by a covered individual to at least one law enforcement agency, a 2 hour reporting limit to law enforcement and state survey agency by a covered individual on suspicion of serious bodily injury, and for all others within 24 hours. The facility policy did not include that the facility would notify covered individuals annually of their reporting obligations, to prevent retaliation if an employee made a report, and post information about employee rights, including the right to file a complaint if a	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 long term care facility retaliated against anyone who filed a report. An interview on 7/31/12 at 2:14 P.M. with administrative nursing staff B agreed the facility policy/procedure on Abuse and Neglect did not include all the required information in the CMS letter. The facility failed to fully develop written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of property.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility identified a census of 25 residents. Based on observation, record review, and staff interview the facility failed to maintain a sanitary and comfortable interior of the facility for 2 of 4 days on site. Findings included: - Observations during the initial tour and stage one on 7/25/12 from 9:00 to 5:00 P.M. on 7/26/12 from 7:00 A.M. to 10;30 A.M. and during environmental tour on 7/26/12 from approximately 2:00 P.M. to 2:35 P.M., revealed the following: Hall B:	F 253		

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F 253	Continued From page 2 * loose and chipped tiles on the floors in resident rooms, resident bathrooms and in the bathing room Hall C: * chipped and loose floor tiles in resident rooms and resident bathrooms Hall D: * chipped floor tiles the bathing room and toilet room * wall plaster/paint peeled in the bathing and toilet room Living Area: * a brown high backed vinyl/leather covered chair with 2 inch tan masking tape on the back/side seam for approximately 18 inches. The masking tape was peeled at the top of the seam. * chipped floor tiles in the hallway between A and B halls An interview on 7/26/12 at approximately 2:30 P.M. with maintenance staff H said they fixed things up as they needed, but did not have a written plan of improvement for maintenance. They just finished remodeling the bathing/toileting room on Hall C and opened it up Monday, 7/23/12. He/she said they next planned to remodel Hall B bathing room. He/she said there were no plans to remodel the bathing/toileting rooms on Hall D because residents no longer resided on that hall. Maintenance staff H said the residents did use Hall D bathing/toileting rooms during the bath/toileting room remodel on Hall C. He/she noted the loose/chipped floor tiles during the environmental tour.	F 253		

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F 253	Continued From page 3 The Policy and Procedure dated 11/8/11 for preventive routine maintenance failed to note specific areas for routine maintenance. The policy note for maintenance staff to check work orders submitted by staff members daily and do environmental rounds monthly. A phone interview on 8/1/12 with maintenance staff H at 3:30 p.m. said members of the safety committee made monthly environmental rounds. He/she said they identified such things as uneven floor areas, jagged and splintered wood and chipped and loose floor tiles, then maintenance staff fixed the areas they identified as they could. He/she said he/she was not sure how they missed the areas of concern revealed to maintenance staff H on the environmental tour. The facility failed to provide housekeeping and maintenance services in a sanitary and comfortable manner for the residents in the facility.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

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highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 25 residents and the sample was 12. Based on observation, record review, and staff interview, the facility failed to develop comprehensive care plans for 2 (#30, #15) residents of the sample.

Findings included:

- Resident #30's 7/13/12 admission Minimum Data Set 3.0 recorded the resident had mild depression, inattention, disorganized thinking, physical behavioral symptoms directed toward others, wandered, and intruded on others, needed extensive assistance with bed mobility/transfer/dressing/toileting, a fall 2-6 months prior to admission, and had no restraints.

The Care Area Assessment dated 7/13/12 for falls recorded the resident had not fallen since admission, he/she was a fall risk and was at risk for injury should he/she fall.

The Evaluation of Side Rail Usage dated 6/21/12 recorded the resident had a history of falls in general, had no falls from the bed, used side rails to adjust position in bed, and had decreased safety awareness due to confusion or judgement

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problems.

The care plan dated 6/20/12 did not address side rail usage.

An observation on 7/25/2012 at 6:10 P.M. the resident's bed had a quarter rail to the outside of the bed. One in between rail was loose and caused a separation at the top of the rail that measured 8 1/2 inches, and at the bottom measured 4 1/2 inches. The other side of the bed was against the wall.

A staff interview on 7/30/12 at 4:00 P.M. with administrative staff C after he/she observed the side rail in the resident's room and said the side rail was broken, and that he/she would report it to maintenance. The staff said the care plan did not include the side rail.

The facility failed to care plan for the use of side rails and for Black Box Warnings for this resident's medications.

- Resident #15's quarterly Minimum Data Set (MDS) dated 7/17/12 reported a Brief Interview for Mental Status (BIMS) of 3 indicating severe impaired cognition. The resident required extensive assistance with bed mobility, transfer, walking, dressing, and toileting. The resident was independent with eating, and required limited assistance with personal hygiene.

The 4/13/12 care plan did not address nutritional status or weight loss.

A review of the weights reported: 4/6/12 -146

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pounds, 5/1/12 -143 pounds, 6/1/12- 142 pounds, 6/3/12 -148 pounds, 6/10/12 -139.7 pounds, 6/17/12- 136.5 pounds, 6/24/12- 136.4 pounds, 7/12- 134 pounds, 7/8/12- 131.8 pounds, 7/15/12 -128.8 pounds, 7/22/12 -134.8 pounds, and 7/29/12- 134.2 pounds.

Admission nutrition assessment by the registered dietician dated 4/6/12, indicated a weight of 146.9. Lab values on 4/10/12 albumin 3.3 (low), and hemoglobin/hematocrit 9.3/27 (low), poor feeding skills, and requests smaller servings. The resident's average oral intake was 60 percent (%). Staff to provide well balanced meals, maintain oral intake greater than 50 percent and weight maintenance within 5 percent.

A dietician note on 4/8/12 indicated the resident's intake was 60% at this time.

A nutrition progress note by consultant staff K on 6/22/12 indicated the June weight was 141.8, May weight 143.2, weight down 1.4 pounds in 1 month, down 5.3 pounds in 2 months. Recommended staff try 30 milliliters (ml) 2 cal twice a day at medication pass to slow weight loss.

A nutrition recommendation sheet dated 7/3/12 indicated staff notified the physician of an 8.5 percent (12.3 pounds) weight loss in the past 90 days, 6 percent (8.1 pounds) weight loss in past month, and physician order dated 7/5/12, 2-cal 30 milliliters three times a day with medication pass.

A nutrition progress note by registered dietician on 7/27/12 indicated July weight 133.7 pounds,

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June 141.8 pounds, and May 143 pounds. Weight down 8 pounds in 1 month, weight down 9.5 pounds in 2 months. The resident was on a low sodium diet. Recommend as stated on 6/22/12, 60 ml (up from 30 ml due to weight decrease).

Review of the medication administration record (MAR) indicated that staff documented 2 cal 30 ml with medication pass initiated on 7/5/12 (recommended by dietician on 6/22). The July 2012 MAR indicated that staff continued to administer 2 cal 30 ml after the dietician recommended an increase to 60 ml on 7/27.

An interview with administrative nursing staff B on 7/31 at 1:45 P.M. indicated dietary staff recorded resident's meal consumption and reported values at the care plan meetings. He/she further stated that he/she expected staff to notify the charge nurse of resident numerous refusals of 2 cal. He/she stated the registered dietician provided him/her with a copy of his/her recommendations and they were then faxed by the charge nurse to the physician.

The facility Weight Loss Identification and Monitoring policy dated 7/5/12 indicated that each resident is weighed at a minimum monthly and compared to the prior month's weight. The nurse and/or dietary manager would add new nutritional interventions to the care plan. The nurse and dietary manager monitored that staff implemented and followed these interventions as care planned.

Observations included on 7/30/12 at 7:40 A.M. the resident fed self in the dining room. Staff

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F 279	Continued From page 8 served the resident toast, bacon sausage, and coffee. On 7/30/12 at 11:45 A.M. the resident sat in dining area eating, fried chicken, green beans, cake and coffee. At 12:05 P.M. resident observed to eat only cake. An interview with direct care staff G on 7/31/12 at 9:30 A.M. reported resident became upset if staff tried to help feed resident. He/she further stated staff gave 2 cal with medication pass. The resident sometimes refused. An interview with administrative nursing staff B on 7/31/12 at 1:45 P.M. indicated that he/she, administrative nursing staff C, and licensed nursing staff were responsible for updating resident care plans. The facility failed to provide an individualized, comprehensive care plan for the dependent resident with weight loss.	F 279		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents	F 323		

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and the sample was 12. Based on observation, record review, and staff interview, the facility failed to assess for the safety of side rails for 2 (#30, and #9) residents of the sample, failed to ensure the environment for 3 of 3 resident hallways remained free of accident hazards.

Findings included:

- Resident #30's 7/13/12 admission Minimum Data Set 3.0 recorded the resident had mild depression, inattention, disorganized thinking, physical behavioral symptoms directed toward others, wandered, and intruded on others, needed extensive assistance with bed mobility/transfer/dressing/toileting, had a fall 2-6 months prior to admission, and had no restraints.

The fall risk assessment dated 6/21/12 recorded a score of 15 which indicated the resident was at a high risk for falling.

The Evaluation of Side Rail Usage dated 6/21/12 recorded the resident had a history of falls in general, had no falls from the bed, used side rails to adjust position in bed, and had decreased safety awareness due to confusion or judgement problems.

The care plan dated 6/20/12 did not address side rail usage.

An observation on 7/25/2012 at 6:10 P.M. the resident's bed had a quarter rail to the outside of the bed. One in between rail was loose and caused a separation at the top of the rail that measured 8 1/2 inches, and at the bottom measured 4 1/2 inches. The other side of the

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bed was against the wall.

A staff interview on 7/30/12 at 4:00 P.M. with administrative staff C after he/she observed the side rail in the resident's room, said the side rail was broken, and that he/she would report it to maintenance. The staff said the care plan did not include the side rail.

According to the Federal Drug Administration (FDA) Hospital Bed Safety Workgroup as of June 2001 revised the dimension within a side rail opening to less than 120 millimeters or 4 3/4 inch to prevent entrapment of body parts.

The facility failed to care plan for the use of side rails and failed to assess the safety of the side rail.

- Resident #9's 7/10/12 quarterly Minimum Data Set 3.0 recorded the resident was severely cognitively impaired, had no behaviors, needed extensive assistance with bed mobility, and transfer, and had no restraints.

The side rail assessment dated 7/9/12 recorded the resident had a history of falls including from the bed, did not attempts to climb over or around the rails, had decreased safety awareness, made attempts to get out of bed, could not get in/out of bed safely without any human assistance or assistive device and used the rail to aid position in bed. Had both quarter rails up.

The care plan dated 10/31/10 recorded the resident liked the top quarter rails up to grab a hold of and help him/herself turn in bed.

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An observation on 7/25/2012 at 3:13 P.M. the resident's bed had a quarter rail to the outside of the bed. One in-between rail was loose and caused a separation at the top of the rail that measured 8 1/2 inches, and at the bottom measured 4 1/2 inches.

A staff interview 7/30/12 at 3:55 P.M. with direct care staff I who said the resident used the side rails to help with transfer/repositioning.

A staff interview on 7/30/12 at 4:00 P.M. with administrative staff C, after he/she observed the side rail in the resident's room and said the side rail was broken, and that he/she would report it to maintenance. At 4:10 P.M. the staff removed the resident's bed and exchanged it with a new one.

According to the Federal Drug Administration (FDA) Hospital Bed Safety Workgroup as of June 2001 revised the dimension within a side rail opening to less than 120 millimeters or 4 3/4 inch to prevent entrapment of body parts.

The facility failed to assess the safety of the side rail.

- Observations during the initial tour and stage one on 7/25/12 from 9:00 to 5:00 P.M. and on 7/26/12 from 7:00 A.M. to 10;30 A.M. and during environmental tour on 7/26/12 from approximately 2:00 P.M. to 2:35 P.M.,revealed the following:

Hall B:
* resident room with jagged and splintered wood along the window sill

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* splintered and jagged wood on the outside door to the bathing/toileting room
* lack of a non-skid surface in the bathing area of the bathing room

Hall C:
* a buckled area in the middle of the hallway (where the a wing addition started), covered with a rubbery substance was buckled on the right side of the hallway in several areas covered about 2 feet in length and loose areas to the left side of the hallway which covered about 1 feet of area

Hall D:
* lack of a non-skid surface in the bathing area of the bathing room

An interview on 7/26/12 at approximately 2:30 P.M. with maintenance staff H said they used the present material to cover the uneven level of the floors where it settled. He/she said it started to loosen up and buckle after only a few months. He/she noted there was not a non-skid surface to any the bathing areas in 2 of 3 bathing/shower rooms, and he/she was not aware of the splintered wood areas. He/she said they fix areas as they came up.

The Policy and Procedure dated 11/8/11 for preventive routine maintenance failed to note specific areas for routine maintenance. The policy note for maintenance staff to check work orders submitted by staff members daily and do environmental rounds monthly.

A phone interview on 8/1/12 with maintenance staff H at 3:30 p.m. said members of the safety

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F 323	Continued From page 13 committee made monthly environmental rounds. He/she said they identified such things as uneven floor areas, jagged and splintered wood and chipped and loose floor tiles, then maintenance staff fixed the areas they identified as they could. He/she said he/she was not sure how they missed the areas of concern revealed to maintenance staff H on the environmental tour. The facility failed to ensure the environment was safe and free of accident hazards for the residents.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility census was 25 residents. The sample included 12 residents with 3 residents reviewed for weight loss. Based on observation, record review, and staff interview, the facility failed to prevent weight loss for 2 of 3 residents (#15 and #28). Findings included:	F 325		

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- Resident #28's 9/19/11 admission Minimum Data Set 3.0 recorded the resident weighed 127 pounds.

The quarterly Minimum Data Set 3.0 dated 6/22/12 recorded the resident was mildly cognitively impaired, had no signs/symptoms of a mood disorder, had no behaviors, was independent with bed mobility, transfer and eating, walked in room with supervision, had no pain, received a diuretic and an anti-depressant, weighed 109 pounds and was 67 inches tall.

The Care Area Assessment (CAA) worksheet for cognitive impairment dated 10/5/11 recorded the resident had progressive dementia, was having difficulty dealing with the issues that his/her dementia created, was an avid reader, was well educated and widely traveled, was recently hospitalized with an acute gastrointestinal (GI) bleed which caused him/her to be more weak/unstable, had no falls, took various medications for hypertension, constipation, hypokalemia, anemia and recent GI bleed, took fluids well, sipped on tap water at bedside, as well as hot tea, juices and milk.

The CAA for nutrition did not trigger.

The record revealed the resident weighed 110 pounds on 7/01/2012,109 pounds on 6/01/2012 , 118 pounds on 3/06/2012, and 132 pounds on 1/01/2012. The resident lost 6.78% from the first weight to the third weight (4 months), and the resident lost 16.67% from the first weight to the fourth weight.(6 months)

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The care plan dated 2/10/12 recorded a list of his/her daily afternoon snack schedule: Monday-pink grapefruit,Tuesday-cucumber, Wednesday-green grapes, Thursday-yogurt, Friday-fresh fruit, Saturday-fresh orange, and Sunday-banana.

Bed time snacks: Tuesday-yogurt, Wednesday-fresh fruit,Thursday-pink grapefruit, Saturday-cucumber, and Sunday-fresh orange. Also listed was low salt soup, and chicken broth in carton.

The care plan listed the following approaches: 1/3/12 Zoloft (an anti-depressant) 25 milligram (mg) daily, 1/4/12 increase Lasix (a diuretic) to 40 mg daily, and complete blood count, comprehensive metabolic panel, 1/9/12 appointment with the physician, and daily weights for 7 days, 2/8/12 Levaquin (an antibiotic) 750 mg for 7 days for pneumonia, 2/14/12 appointment with the physician for severe headache, 2/15/12 increase Zoloft to 50 mg for depression, 2/20/12 change diet to regular with super cereal daily at breakfast, 3/13/12 a 2 cal supplement at medication pass three times daily, 3/19/12 discontinue 2 cal as resident refused the supplement, and 7/11/12 Megace (an appetite stimulant) 80 mg twice daily.

The care plan did not address weight loss as a problem and did not state any goals.

The admission nutritional assessment dated 9/7/11 by the registered dietician, recorded the resident's height was 67 inches, weight 127.3 pounds, Carnation Instant Breakfast discontinued

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as the resident preferred fruit as snacks, will watch weight, and maintain intake over 50-75% at meals.

The resident food preferences dated 9/10/11 recorded the resident received a regular diet, loved baked potatoes, liked scrambled eggs, toast, oatmeal, sausage, bacon for breakfast, entrees such as chicken, macaroni/cheese, rice casserole, liked fruit, bananas/berries/peach, preferred fruit over sweets, and did not like tomatoes.

Nutrition note dated 1/25/12 recorded the resident's weight was 125.5 pounds on 1/15/12, food intake was 53% for December 2011, and received 75% of meals in his/her room.

Nutrition note dated 2/18/12 by registered dietitian recorded resident weighed on 2/12, 127 pounds, 1/12, 131.5 pounds, 12/11, 132.6 pounds, weight down 4.2 pounds in 1 month, 5.6 pounds in 2 months, received a low salt diet, the resident had difficulty with headaches, had recent pneumonia, exacerbation of lung disease, resident was slightly under weight, recommend diet change to regular diet with super cereal at breakfast to get weight back near normal range.

Nutrition notes 3/13/12 by registered dietician recorded the resident's March 2012 weight was 117.6 pounds, 2/12 was 127 pounds, 12/11 was 132.6 pounds, weight down 9.4 pounds in 1 month, weight down 15 pounds in 3 months, had regular diet with super cereal, daily 39% intake, had mastoiditis (an infection of the mastoid bone of the skull. The mastoid bone was located just behind the outside ear), no new laboratory

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results, resident with increased weight loss, recommend to start 30 milliliter (ml) 2 cal three times daily to slow weight loss.

Nutrition note dated 7/26/12, the resident's weight on 7/12 was 110 pounds, on 6/12, 109 pounds, food intake was 61 % in 30 days, weight increase 0.9 pounds in 30 days, resident requested his/her food and drink choices for most meals, will continue to monitor.

The list of residents who received supplements and super cereal provided by the kitchen revealed the resident did not receive any supplements and did not receive super cereal at breakfast.

An observation on 7/30/12 at 8:15 A.M. the resident sat in his/her wheel chair at the breakfast table eating a bowl of oatmeal independently. The resident ate approximately 50-60%.

An interview on 7/31/12 at 7:30 A.M. with administrative nursing staff B stated the resident had a lot of edema, and the physician increased the Lasix dose on 1/4/12 from 20 milligram (mg) to 40 mg, and it remained at 40 mg. The staff said the resident was on weekly weights, and the facility notified the physician after each weight loss. The staff said the resident refused often to be weighed. The staff said they gave the resident snacks in the middle of the night as he/she often asked for it. The staff said the resident had weight loss, the care plan listed the approaches, but that there were no problem statement or goals listed.

An interview on 7/31/12 at 7:44 A.M. with dietary staff F said he/she had a list of residents who

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received super cereal at breakfast, revealed the resident's name was not on the list, but should be, and wrote the resident's name on the list and informed the cook.

An interview 7/31/12 at 9:00 A.M. with dietary staff F said the registered dietician on 2/18/12 recommended super cereal for breakfast, changed the diet to regular, but super cereal just was not on our list. The staff said the registered dietician came in once a month, but if he/she needed him/her more frequently, he/she communicated with him/her via phone or fax. The staff said he/she gave the registered dietician all his/her weight concerns weekly and monthly, and compiled meal percentages monthly. The staff said the dietician on 3/13/12 recommended the supplement, 2 cal.

An interview with the resident on 7/31/12 at 11:20 A.M. the resident was alert and oriented said he/she lost weight, did not know why, and said he/she was probably a bit underweight for his/her height.

An interview 8/1/12 with consultant K at 1:25 P.M. said he/she came to the facility on a monthly basis and he/she sat down with dietary staff F and talked over all the residents who the facility brought to his/her attention with a nutrition concern. He/she then filled out a Request for Diet Changes form with all his/her recommendations and left that with administrative nursing staff B or with the charge nurse, and wrote a separate form for the physician's signature, if his/her recommendation needed a physician's order. When he/she returned the following month, he/she would not check to see if the facility

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followed up on his/her recommendation unless the facility brought the resident to his/her attention again because of a nutrition concern. The staff said they did not go back to each chart to check if staff followed his/her recommendation, or if staff discontinued a recommendation because of resident refusal. The staff said he/she had verbal discussions with the facility staff on how residents were doing. When asked how communication could be more effective between facility staff and consultant, the consultant said they felt the Request for Diet Change form that he/she utilized to make recommendations had 2 additional columns on it titled Comments and Date Completed was underutilized.

The facility failed to provide recommended nutritional interventions as planned, and failed to reassess after the resident refused a nutritional supplement for this resident with significant weight loss.

The admission Minimum Data Set (MDS) dated 4/18/12 for resident #15 indicated a weight of 146. The quarterly MDS dated 7/17/12 reported a weight of 134, and a Brief Interview for Mental Status (BIMS) of 3 indicating severely impaired cognition. The resident required extensive assistance with bed mobility, transfer, walking, dressing, and toileting. The resident was independent with eating.

The 4/13/12 care plan did not address nutritional status or weight loss.

Review of the weights reported: 4/6/12 -146 pounds, 5/1 -143 pounds, 6/1- 142 pounds,

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6/3/12- 148 pounds, 6/10/12 -139.7 pounds, 6/17/12 -136.5 pounds, 6/24/12 -136.4 pounds, 7/1/12-134 pounds, 7/8/12- 131.8 pounds, 7/15--128.8 pounds, 7/22/12 134.8 pounds, and 7/29/12- 134.2 pounds indicating an overall weight loss of 8%.

A 4/6/12 (admission date) nutrition assessment by the registered dietician indicated a weight of 146.9 pounds. Lab values on 4/10/12 listed albumin level at 3.3 (low), and hemoglobin/hematocrit 9.3/27 (low). He/she had poor feeding skills, and requested smaller servings. The resident's average oral intake was 60 percent. The facility was to provide well balanced meals and the resident to maintain an oral intake greater than 50 percent and maintain weight within 5 percent.

A nutrition progress note by the registered dietician on 4/8/12 indicated the resident's food intake was 60 percent at this time and he/she would continue to monitor.

A nutrition progress note by registered dietician on 6/22/12 indicated the June weight was 141.8 pounds, May weight was 143.2 pounds. The resident's weight was down 1.4 pounds in 1 month, down 5.3 pounds in 2 months. The resident received a low sodium (diet) and had 62-86 percent intake. Laboratory results dated 6/19/12 revealed the albumin level was 3, normal was 3.5-5.2. Anemia, malaise, fatigue, altered mental status, dementia, intake fair but was decreased. Weight was 141.8 pounds. Recommend the facility try 30 milliliters 2 cal (nutritional supplement) twice a day at medication pass to slow the resident's weight loss.

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A nutrition recommendation sheet dated 7/3/12 indicated staff notified the physician of an 8.5 percent (12.3 pounds) weight loss in the past 90 days, 6 percent (8.1 pounds) weight loss in past month, and physician order on 7/5/12 of 2-cal 30 milliliters three times a day with medication pass.

A nutrition progress note by registered dietician on 7/27 indicated the July weight 133.7 pounds, June 141.8 pounds, May 143 pounds, down 8 pounds in 1 month, and weight down 9.5 pounds in 2 months. The resident received a low sodium diet. Albumin 3 (normal 3.5-5.2). The physician requested diet consult. The dietician did not recommend a supplement due to increased Blood Urea Nitrogen level (BUN) and creatinine, but did recommend as stated on 6/22/12 (2 cal 30 ml twice a day). Recommend facility staff to start med pass 60 ml (up from 30 ml due to weight decrease).

Review of meal the consumption records indicated an average intake in July of 49% and the dietician progress notes indicated 60% intake in April, and 62-86 % intake in May/June.

Review of the medication administration record (MAR) indicated staff documented 2 cal 30 ml with medication pass initiated on 7/5/12 (recommended by dietician on 6/22/12). Further review of the July 2012 MAR indicated the resident refused 2 cal 13 times, and staff continued to administer 2 cal 30 ml through July, after the the dietician recommended an increase from 30 ml to 60 ml on 7/27/12.

A review of albumin levels (a measure of the

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protein level in the blood) indicated the following, 4/10/12 3.3 (normal range of 3.5-5.2), 4/25/12 3.5 (normal range), 5/2/12, 3.4 (low), 5/9/12 3.3 (low), 6/12/12 3.2 (low), and 6/19/12 3.1(low).

Observation on 7/30/12 at 7:40 A.M. the resident fed him/herself in the dining room, toast, bacon sausage, and coffee.

On 7/30/12 at 11:45 A.M. the resident sat in the dining area, staff served him/her fried chicken, green beans, cake and coffee. At 12:05 P.M. the resident ate only cake.

An interview with direct care staff G on 7/31/12 at 9:30 A.M. reported the resident became upset if the staff tried to help feed resident. He/she further stated staff attempted to give 2 cal with medication pass, but that sometimes the resident refused.

An interview with administrative nursing staff B on 7/31/12 at 1:45 P.M. indicated dietary staff recorded the resident's meal consumption and reported values at care plan meetings. He/she further stated that he/she expected staff to notify the charge nurse if a resident had numerous refusals of 2 cal. He/she stated the registered dietician provided him/her with a copy of his/her recommendations and they were then faxed by the charge nurse to the physician. He/she acknowledged that interventions recommended on 6/22/12 were not initiated until 7/5/12.

An interview on 8/1/12 at 1:25 P.M. with consultant staff J indicated that during his/her monthly visit the facility provided him/her with a list of concerns including weight loss, which

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administrative nursing staff B and/or dietary staff F completed. He/she stated that he/she completed a Request for Diet Changes when he/she had recommendations to communicate to facility staff and the physician. He/she stated that he/she gave the completed form to administrative nurse staff B or the charge nurse, for a physician's order. Consultant J stated that 2 cal required a physician's order. When he/she returned the following month, he/she would not check to see if the facility followed up on his/her recommendation unless the facility brought the resident to his/her attention again because of a nutrition concern.

The facility Weight Loss Identification and Monitoring policy dated 7/5/12 indicated staff weighed each resident monthly, at a minimum, and compared with the prior month's weight. The dietary manager contacted the consulting dietician for a full review of resident's needs, and for recommendations for nutritional interventions. The nurse notified the provider of any recommendations the dietician wrote which required a physician order. Recommended dietary interventions which did not require a physician's order will be implemented and monitored by the nurse and the dietary manager. The nurse and/or dietary manager added new nutritional interventions to the care plan. The nurse and dietary manager monitor that interventions occurred as care planned.

The clinical record lacked evidence weight loss was unavoidable. The facility failed to assess and implement interventions, in a timely manner, for this dependent resident with declining intake and weight to prevent weight loss.

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F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents and the sample was 12. Based on observation, record review, and staff interview, the facility failed to identify and monitor side effects for 4 (#3, #9, #30, #10) residents out of 10 residents sampled for drug review. Findings included:	F 329		

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- Resident #3 Physician Order Sheet (POS) for July 2012 recorded the resident's medication included Buspar, an anti-anxiety medication for anxiety, and Seroquel, an anti-psychotic medication for dementia with behaviors.

The quarterly Minimum Data Set (MDS) 3.0 dated 5/1/12 recorded a score of 1 (severely impaired) on the Brief Interview for Mental Status (BIMS), independent without set up with bed mobility, transfers, walking in room/corridor, locomotion on unit, eating, toilet use, and personal hygiene; required limited assist of one staff with dressing and bathing; balance not steady but resident able to stabilize without staff assistance; continent of bowel and bladder and received anti-psychotic and anti-anxiety medication.

The Care Area Assessment (CAA) dated 8/9/11 documented the psychiatrist followed the resident on a quarterly and as needed basis. The risk benefit statements appear in the psychiatrist's dictated notes. Medication reduction trials were attempted and the resident currently received Seroquel and Buspar. The resident had psychiatric issues and required psychotropic medication for the past several years.

The Lexi-Comp Drug Reference Handbook of Geriatric Dosage Handbook, 16 th edition, recorded the following U.S. Boxed Warning for Seroquel: "Elderly patients with dementia-related psychosis treated with anti-psychotics are at an increased risk of death compared to placebo. Most deaths appeared to be either cardiovascular or infectious in nature. Seroquel is not approved for the treatment of dementia-related psychosis."

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The care plan listed the U.S. Boxed Warnings for Tramadol, Tylenol, and Lasix but did not include the medication Seroquel.

Review of the facility policy/procedure of Maintaining Black Box Warning Alerts dated 11/2011 recorded a medication identified as having a Black Box Warning (BBW). The facility listed the specific medication warning attached to the care plan and placed in the BBW book, which staff kept on the side of the medication cart for review as needed.

Review of the facility policy/procedure of Use of Behavior Monitoring Sheets dated 8/2011 recorded for staff to maintain a quantitative record of targeted behaviors for residents receiving anti-psychotic, anti-anxiety, and sedative/hypnotic drugs, to assist in evaluation of the need to decrease or increase medication based on occurrence of behaviors.

Review of Behavior Monitoring Flow Sheets dated 4/2012, 5/2012, and 6/2012 identified the target behaviors of hitting, annoying peers, anxiety, wandering in and out of peers rooms, throwing things, cursing, inappropriate contact with male peers and pouting, but did not indicate the corresponding medication as Buspar, an anti-anxiety medication, or Seroquel, an anti-psychotic medication.

An observation on 7/31/12 at 12:33 P.M. the resident ambulated throughout the facility while he/she carried a magazine and purse.

A staff interview on 7/31/12 at 9:43 A.M. with

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direct care staff G stated medication aides monitored the resident's behaviors, but the licensed nursing staff documented the behaviors on the behavior monitoring flow sheets.

A staff interview on 7/31/12 at 2:00 P.M. with licensed nursing staff D reported staff kept behavior monitoring flow sheets in the behavior monitoring notebook and when a resident exhibited a specific behavior the licensed nursing staff documented the behavior.

A staff interview on 7/31/12 at 7:30 A.M. with administrative nursing staff B reported he/she was unaware that Seroquel had a Black Box Warning and the pharmacist did not notify him/her if Seroquel had a BBW.. He/she was unaware of need to identify target behaviors for different drug classifications but would rectify this immediately.

The facility failed to identify and monitor for the side effects of a medication with Black Box Warning and failed to monitor for the effectiveness of anti-anxiety and anti-psychotic medication for this cognitively impaired resident.

- Resident #30's 7/13/12 admission Minimum Data Set 3.0 recorded the resident had mild depression, inattention, disorganized thinking, physical behavioral symptoms directed toward others, wandered, and intruded on others, needed extensive assistance with bed mobility/transfer/dressing/toileting, and had a fall 2-6 months prior to admission.

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The record lacked any Abnormal Involuntary Movement Scale (AIMS) assessment.

The care plan dated 6/20/12 recorded the resident had combative behaviors, and that the resident used both arms to strike out at staff who tried to help him/her remain safely inside the building, The care plan recorded the resident dealt with depression and received Celexa (an anti-depressant) 20 milligrams (mg) daily. The care plan recorded the resident had a diagnosis of psychosis and received Seroquel (an anti-psychotic) 12.5 mg at 3:00 P.M., and for the staff to monitor for adverse side effects. The resident received Olanzapine (an anti-psychotic) 5 mg as needed every 4 hours for dementia with behaviors and listed the potential side effects. The care plan recorded that the resident could become quite agitated, especially when the resident became angry. The care plan recorded the resident took Metformin 500 mg for diabetes.

The care plan did not identify the U.S. Black Box Warnings for Seroquel, Olanzapine, and Metformin.

The behavior monitoring sheets for 6/12, and 7/12 recorded the following behaviors: yelling/attempting to elope/hitting/kicking, and listed the following medications: Seroquel 12.5 mg at 3:00 P.M. and Ativan 1 mg every 6 hours as needed.

The Geriatric Dosage Handbook, 16 th Edition, page 1509 recorded for Quetiapine (Seroquel): Warning/Precautions (U.S. Boxed Warning): patients with dementia-related psychosis treated

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with antipsychotics were at an increased risk of death compared to placebo. Quetiapine was not approved for treatment of dementia related psychosis.

The Geriatric Dosage Handbook, 16 th Edition, page 1276 recorded for Olanzapine: Warning/Precautions (U.S. Boxed Warning): patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo. Most deaths appear to be either cardiovascular or infectious in nature. In addition, an increased incidence of cerebrovascular effects has been reported.

The Geriatric Dosage Handbook, 16 th Edition, page 1101 recorded for Metformin: Warning/Precautions (U.S. Boxed Warning): Lactic acidosis as a rare, but potentially severe consequence of therapy with Metformin.

An observation on 7/30/12 at 7:30 A.M. the resident sat in the wheel chair by the aviary and appeared to nap.

An interview 7/3/12 at 7:15 A.M. with administrative staff B said regarding the resident's behavior monitoring sheets the facility listed the specific behaviors the staff monitored, listed 2 different drugs, Ativan (an anti-anxiety) and Seroquel (an anti-psychotic) but did not specify which behaviors related to which of the drugs, which made it difficult for the staff to monitor the medications for efficacy.

An interview 7/31/12 at 1:15 P.M. with administrative nursing staff B said they were unaware that Seroquel had a Black Box Warning,

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and reported the care plan did not include this resident's Black Box Warning medication.

The facility failed to identify which behaviors related to which psychotropic medication on the behavior monitoring form for the monitoring of efficacy, failed to care plan for the Black Box Warning medication, and failed to monitor the anti-psychotic medication for potential adverse effects.

- Resident #9's 7/10/12 quarterly Minimum Data Set 3.0 recorded the resident was severely cognitively impaired, had no behaviors, needed extensive assistance with bed mobility, and transfer, and received an anti-depressant medication.

The Care Area Assessment worksheet dated 10/11/11 for mood state recorded the resident had a diagnosis of depression and took Paxil 20 milligrams (mg) daily. Because of the resident's Parkinson's disease with it's mask like faces the resident appeared more depressed than he/she often actually was. The resident became moody at times, but appeared stable on Paxil at this time.

The care plan dated 10/31/10 indicated the resident had social isolation due to Parkinson's disease related dementia and severe hearing loss, and had a history of depression/hallucinations/delusions, needed one staff for most activities of daily living cares, received Paxil for depression, and for the staff to observe for changes in mental status and document abnormal behaviors every shift.

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The physician progress note 7/11/12 recorded the resident slept well, had previously reported vivid dreams, in no apparent distress and with no resting tremor.

An observation on 7/26/2012 at 2:30 P.M. the resident sat in his/her easy chair in their room napping.

An interview 7/31/12 at 7:15 A.M. with administrative staff B said the facility had not attempted a dose reduction for Paxil. The resident had been on Paxil since 6/11.

The facility failed to attempt a timely dose reduction for Paxil.

- Resident #10's annual Minimum Data Set 3.0 dated 6/5/12 recorded the resident was cognitively intact, had behaviors, was independent with all activities of daily living, and received anti-psychotic and anti-depressant medications.

The Care Area Assessment worksheet dated 6/5/12 for psychotropic medication recorded a psychiatrist followed the resident for behavioral problems & medication management, received Zyprexa (anti-psychotic) medication for dementia related behaviors, and Remeron for depression.

The care plan dated 5/26/11 for potential for socially inappropriate behavior recorded the resident sometimes felt sad/anxious, hoarding, accusatory behaviors, easily believed others were against him/her, " I could get upset and try to

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F 329	Continued From page 32 leave unattended, at times I threaten others when angry, or touched female residents" and for the staff to help keep my appointments with the psychiatrist, and "if I am upset because I think someone took something from me, listen to me supportively and help me with legitimate concerns, remind me as needed not to touch female residents.." The behavior sheet dated 6/12 and 7/12 recorded the following behaviors: delusions/paranoia/refusal of cares, and the following medications: Zyprexa 2.5 milligram (mg) and Remeron 30 mg. An observation on 7/31/12 at 9:00 A.M. the resident sat in his/her wheel chair in the living room, waiting to go out on an outing. An interview 7/31 at 7:15 A.M. with administrative staff B said regarding the resident's behavior monitoring sheets the facility listed the specific behaviors the staff monitored, and listed 2 different drugs, Zyprexa (an anti-anxiety) and Remeron (an anti-depressant) but did not specify which behaviors related to which of the drugs, which made it difficult for the staff to monitor the medications for efficacy. The facility failed to identify which behaviors related to which psychotropic medication on the behavior monitoring form for the monitoring of efficacy.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428		

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F 428	Continued From page 33 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents and the sample was 12. Based on observation, record review, and staff interview, the facility drug regimen review failed to identify and report drug irregularities for 4 (#3, #9, #30, #10) residents out of 10 residents sampled for drug review. Findings included: - Resident #3 Physician Order Sheet (POS) for July 2012 recorded the resident's medication included Buspar, an anti-anxiety medication for anxiety, and Seroquel, an anti-psychotic medication for dementia with behaviors. The quarterly Minimum Data Set (MDS) 3.0 dated 5/1/12 recorded a score of 1 (severely impaired) on the Brief Interview for Mental Status (BIMS), independent without set up with bed mobility, transfers, walking in room/corridor, locomotion on unit, eating, toilet use, and personal hygiene; required limited assist of one staff with dressing and bathing; balance not steady but resident able to stabilize without staff assistance; continent of bowel and bladder and received anti-psychotic and anti-anxiety medication.	F 428		

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The Care Area Assessment (CAA) dated 8/9/11 documented the psychiatrist followed the resident on a quarterly and as needed basis. The risk benefit statements appear in the psychiatrist's dictated notes. The facility attempted medication reduction and the resident currently received Seroquel and Buspar. The resident had psychiatric issues and required psychotropic medication for the past several years.

The Lexi-Comp Drug Reference Handbook of Geriatric Dosage Handbook, 16 th edition, recorded the following U.S. Boxed Warning for Seroquel: "Elderly patients with dementia-related psychosis treated with anti-psychotics are at an increased risk of death compared to placebo. Most deaths appeared to be either cardiovascular or infectious in nature. Seroquel is not approved for the treatment of dementia-related psychosis."

The care plan listed the U.S. Boxed Warnings for Tramadol, Tylenol, and Lasix but did not include the medication Seroquel.

Review of the facility policy/procedure of Maintaining Black Box Warning Alerts dated 11/2011 recorded a medication identified as having a Black Box Warning (BBW). The facility listed the specific medication warning attached to the care plan and placed in the BBW book, which staff kept on the side of the medication cart for review as needed.

Review of the facility policy/procedure of Use of Behavior Monitoring Sheets dated 8/2011 recorded for staff to maintain a quantitative record of targeted behaviors for residents

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receiving anti-psychotic, anti-anxiety, and sedative/hypnotic drugs, to assist in evaluation of the need to decrease or increase medication based on occurrence of behaviors.

Review of Behavior Monitoring Flow Sheets dated 4/2012, 5/2012, and 6/2012 identified the target behaviors of hitting, annoying peers, anxiety, wandering in and out of peers rooms, throwing things, cursing, inappropriate contact with male peers and pouting, but did not indicate the corresponding medication as Buspar, an anti-anxiety medication, or Seroquel, an anti-psychotic medication.

Review of the Pharmacist Communication Sheet dated 7/20/12, 6/18/12, 5/15/12, 4/16/12, 3/7/12, 2/15/12, 1/18/12, 12/15/11, and 11/16/11 failed to identify the medication irregularities.

An observation on 7/31/12 at 12:33 P.M. the resident ambulated throughout the facility while he/she carried a magazine and purse.

A staff interview on 7/31/12 at 9:43 A.M. with direct care staff G stated medication aides monitored the resident's behaviors, but the licensed nursing staff documented the behaviors on the behavior monitoring flow sheets.

A staff interview on 7/31/12 at 2:00 P.M. with licensed nursing staff D reported staff kept behavior monitoring flow sheets in the behavior monitoring notebook and when a resident exhibited a specific behavior the licensed nursing staff documented the behavior.

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A staff interview on 7/31/12 at 7:30 A.M. with administrative nursing staff B reported he/she was unaware that Seroquel had a Black Box Warning and the pharmacist did not notify him/her if Seroquel had a BBW. He/she was unaware of need to identify target behaviors for different drug classifications but would rectify this immediately.

An interview on 8/1/12 at 10:57 A.M. with consultant pharmacist J revealed he/she monitored the medication regime on a monthly basis. He/she monitored medications for supporting diagnosis, monitored lab work as related to prescribed medications, and monitored medications for potential drug dosage reduction. He/she alerted staff of medications with Black Box Warnings (BBW) and monitored for presence/lack of behavior monitoring sheets.

The facility failed to ensure pharmacy consultant J identified and reported to the physician and the facility the medication irregularities.

- Resident #30's 7/13/12 admission Minimum Data Set 3.0 recorded the resident had mild depression, inattention, disorganized thinking, physical behavioral symptoms directed toward others, wandered, and intruded on others, needed extensive assistance with bed mobility/transfer/dressing/toileting, had a fall 2-6 months prior to admission, and had no restraints.

The Care Area Assessment dated 7/13/12 for falls recorded the resident had not fallen since admission, he/she was a fall risk and was at risk for injury should he/she fall.

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The record lacked any Abnormal Involuntary Movement Scale (AIMS) assessment.

The care plan dated 6/20/12 recorded the resident had combative behaviors, and the resident used both arms to strike out at staff who tried to help him/her remain safely inside the building, The care plan recorded the resident dealt with depression and received Celexa (an anti-depressant) 20 milligrams (mg) daily. The care plan recorded the resident had a diagnosis of psychosis and received Seroquel (an anti-psychotic) 12.5 mg at 3:00 P.M., and for the staff to monitor for adverse side effects. The resident received Olanzapine (an anti-psychotic) 5 mg as needed every 4 hours for dementia with behaviors and listed the potential side effects. The care plan recorded that the resident could become quite agitated, especially when the resident became angry. The care plan recorded the resident took Metformin 500 mg for diabetes.

The care plan did not identify the U.S. Black Box Warnings for Seroquel, Olanzapine, and Metformin.

The behavior monitoring sheets for 6/12, and 7/12 recorded the following behaviors: yelling/attempting to elope/hitting/kicking, and listed the following medications: Seroquel 12.5 mg at 3:00 P.M. and Ativan 1 mg every 6 hours as needed.

The Geriatric Dosage Handbook, 16 th Edition, page 1509 recorded for Quetiapine (Seroquel): Warning/Precautions (U.S. Boxed Warning): patients with dementia-related psychosis treated

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with antipsychotics are at an increased risk of death compared to placebo. Quetiapine was not approved for treatment of dementia related psychosis.

The Geriatric Dosage Handbook, 16 th Edition, page 1276 recorded for Olanzapine: Warning/Precautions (U.S. Boxed Warning): patients with dementia-related psychosis treated with antipsychotics were at an increased risk of death compared to placebo. Most deaths appear to be either cardiovascular or infectious in nature. In addition, an increased incidence of cerebrovascular effects has been reported.

The Geriatric Dosage Handbook, 16 th Edition, page 1101 recorded for Metformin: Warning/Precautions (U.S. Boxed Warning): Lactic acidosis was a rare, but potentially severe consequence of therapy with Metformin.

The monthly drug regimen review dated 7/20/12 did not identify any irregularities.

An observation on 7/30/12 at 7:30 A.M. the resident sat in the wheel chair by the aviary and appeared to nap.

An interview 7/3/12 at 7:15 A.M. with administrative staff B said regarding the resident's behavior monitoring sheets the facility listed the specific behaviors the staff monitored, listed 2 different drugs, Ativan (an anti-anxiety) and Seroquel (an anti-psychotic) but did not specify which behaviors related to which of the drugs, which made it difficult for the staff to monitor the medications for efficacy. The staff said he/she was sure the pharmacist did not

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notify the facility regarding the behavior monitoring sheets, because had they he/she would have changed it.

An interview 7/31/12 at 1:15 P.M. with administrative nursing staff B said they were unaware that Seroquel had a Black Box Warning, and reported the care plan did not include this resident's Black Box Warning medication.

An interview 8/1/12 at 10:57 A.M. with pharmacy consultant J said he/she reviewed monthly each resident's charts, monitored if residents were on psychotropic medication and possibly needed a dose reduction, monitored laboratory values, and monitored for appropriate diagnosis. The consultant DJ said they assisted the facility in identifying Black Box Warning medications, he/she checked to see if the facility completed the behavior monitoring sheets but did not direct how the facility monitored medications and behaviors.

The facility consultant J failed to identify medication irregularities.

- Resident #9's 7/10/12 quarterly Minimum Data Set 3.0 recorded the resident was severely cognitively impaired, had no behaviors, needed extensive assistance with bed mobility, and transfer, and received an anti-depressant medication.

The Care Area Assessment worksheet dated 10/11/11 for mood state recorded the resident had a diagnosis of depression and took Paxil 20 milligrams (mg) daily. Because of the resident's Parkinson's disease with it's mask like faces, the

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resident appeared more depressed than he/she often actually was. The resident became moody at times, but appeared stable on Paxil at this time.

The care plan dated 10/31/10 indicated the resident had social isolation due to Parkinson's disease related dementia and severe hearing loss, and had a history of depression/hallucinations/delusions, needed one staff for most activities of daily living cares, received Paxil for depression, and for the staff to observe for changes in mental status and document abnormal behaviors every shift.

The physician progress note 7/11/12 recorded the resident slept well, had previously reported vivid dreams, in no apparent distress and with no resting tremor.

The monthly drug regimen review dated 7/26/12, 6/18/12, 5/15/12, 4/16/12, 3/7/12, 2/15/12, 1/18/12, and 12/15/11 failed to identify dose reduction for Paxil.

An observation on 7/26/2012 at 2:30 P.M. the resident sat in his/her easy chair in their room napping.

An interview 7/31/12 at 7:15 A.M. with administrative staff B said the facility had not attempted a dose reduction for Paxil. The resident had been on Paxil since 6/11.

An interview 8/1/12 at 10:57 A.M. with pharmacy consultant J said he/she reviewed monthly each resident's charts, monitored if residents were on psychotropic medication and possibly needed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY MEM HOSPITAL LTCU	408 DELAWARE STREET WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 41	F 428		

dose reduction, monitored laboratory values, and monitored for appropriate diagnosis. The consultant DJ said they assisted the facility in identifying Black Box Warning medications, he/she checked to see if the facility completed the behavior monitoring sheets but did not direct how the facility monitored medications and behaviors.

The facility consultant J failed to identify medication irregularities.

- Resident #10's annual Minimum Data Set 3.0 dated 6/5/12 recorded the resident was cognitively intact, had behaviors, was independent with all activities of daily living, and received anti-psychotic and an anti-depressant medication.

The Care Area Assessment worksheet date 6/5/12 for psychotropic medication recorded the resident was followed by a psychiatrist for behavioral problems & medication management, received Zyprexa (anti-psychotic) medication for dementia related behaviors, and Remeron for depression.

The care plan dated 5/26/11 for potential for socially inappropriate behavior recorded the resident sometimes felt sad/anxious, hoarding, accusatory behaviors, easily believed others were against him/her, " I could get upset and try to leave unattended, at times I threaten others when angry, or touched female residents" and for the staff to help keep my appointments with the psychiatrist, and "if I am upset because I think someone took something from me, listen to me supportively and help me with legitimate

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F 428	Continued From page 42	F 428		

concerns, remind me as needed not to touch female residents.."

The monthly drug regimen review dated 7/20/12, 6/18/12, 5/15/12, 4/16/12, 3/7/12, 2/15/12, 1/18/12, and 12/15/11 did not identify any irregularities.

The behavior sheet dated 6/12 and 7/12 recorded the following behaviors: delusions/paranoia/refusal of cares, and the following medications: Zyprexa 2.5 milligram (mg) and Remeron 30 mg.

An observation on 7/31/12 at 9:00 A.M. the resident sat in his/her wheel chair in the living room, waiting to go out on an outing.

An interview 7/31 at 7:15 A.M. with administrative staff B said regarding the resident's behavior monitoring sheets the facility listed the specific behaviors the staff monitored, and listed 2 different drugs, Zyprexa (an anti-anxiety) and Remeron (an anti-depressant) but did not specify which behaviors related to which of the drugs, which made it difficult for the staff to monitor the medications for efficacy.

An interview 8/1/12 at 10:57 A.M. with pharmacy consultant J said he/she reviewed monthly each resident's charts, monitored if residents were on psychotropic medication and possibly needed a dose reduction, monitored laboratory values, and monitored for appropriate diagnosis. The consultant J said they assisted the facility in identifying Black Box Warning medications, he/she checked to see if the facility completed the behavior monitoring sheets but did not direct how

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F 428	Continued From page 43 the facility monitored medications and behaviors. The facility consultant J failed to identify medication irregularities.	F 428		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: The facility identified a census of 25 residents. Based on observation, record review, and staff interview the facility failed to maintain adequate outside ventilation in the personal care room for one of four days on site of the survey. Findings included: - During environmental tour on 7/26/12 at approximately 2:00 P.M. to 2:35 P.M. with maintenance staff H, observation identified the personal care room (beauty shop) did not have any means of outside mechanical or window ventilation. The room lacked an exhaust vent and also lacked any windows which opened to the outside. An interview with maintenance staff H at approximately 2:20 P.M. on 7/26/12, revealed the personal care room lacked any means of ventilation. The facility failed to have a policy for adequate ventilation in the personal care room.	F 467		

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F 467	Continued From page 44 The facility failed to maintain adequate ventilation for the personal care room.	F 467		